

## No Surprises Act

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### Issue

Briefly summarize the surprise billing provisions of the federal No Surprises Act ([P.L. 116-260](#), Division BB, Title 1), including the state's role in establishing provider reimbursement amounts for these bills.

The Office of Legislative Research is not authorized to provide legal opinions and this report should not be considered one.

### Summary

The federal No Surprises Act, established as part of the Consolidated Appropriations Act of 2021, places requirements on health insurers and health care providers that are designed to protect consumers in surprise billing situations. In practice, "surprise billing" refers to large, unexpected bills charged to individuals by out-of-network providers at in-network facilities. Beginning January 1, 2022, the No Surprises Act prohibits surprise billing for (1) out-of-network emergency services, including air ambulance (but not ground ambulance) services and (2) in-network nonemergency services provided under certain circumstances. The act applies to self- and fully-insured health insurance plans.

In these surprise billing situations, the act generally requires health carriers (i.e., insurers and plan administrators of self-insured plans) to bill patients at the in-network level of service and calculate patient cost-sharing based on in-network rates. By establishing the maximum patient responsibility for emergency and non-emergency surprise bills, the act also prohibits balance billing for these services. ("Balance billing" refers to providers billing patients for the difference between a service's cost and the amount the health carrier reimburses the provider for the service.)

The act also provides a methodology for calculating how much insurers pay providers in surprise billing situations. However, this federal methodology does not apply in states that have their own surprise billing laws or an all-payer model agreement. According to the federal Centers for Medicare and Medicaid Services (CMS), Connecticut's existing state laws governing provider reimbursements for these services will apply for purposes of determining the out-of-network rate in specified situations (see attached). Additional details of the payment methodology will be clarified when the relevant federal agencies publish the final rule.

#### *All-Payer Model Agreements*

An all-payer model is a type of Medicaid demonstration waiver that allows states to establish prices for certain health care services for all Medicaid, Medicare, and commercial payors (e.g., insurers). Currently, [Maryland](#) and [Vermont](#) have such agreements.

In addition to these surprise billing provisions, the act imposes several other requirements on health carriers. For example, it includes additional consumer notification requirements and requires carriers to provide insureds with a good faith cost estimate before a service. In addition, it requires carriers to offer price comparison information by phone and develop an online price comparison tool. Among other things, the act also (1) requires insurers to allow a parent to designate a pediatrician as the primary care provider (PCP) for a child if the plan requires a PCP, and (2) prohibits insurers from requiring prior authorization or referrals for obstetrical and gynecological care ([42 U.S.C. § 300gg-117\(b\) & \(c\)](#)). It also establishes a ground ambulance advisory group to study how ambulance patients are impacted by balance billing and other factors ([P.L. 116-260 § 117](#)).

As with many other federal insurance laws, the state is responsible for enforcing the law's provisions on fully insured health insurance products, while the federal government is responsible for doing so for self-insured plans (i.e. plans covered under the federal Employee Retirement Income Security Act (ERISA)).

## **Emergency Services**

Generally, the act requires group health plans (i.e., employer sponsored plans governed under ERISA) and group and individual health insurance policies that cover emergency services to cover them:

1. without the need for prior authorization;
2. regardless of whether the provider is in- or out-of-network; and
3. at the in-network level of benefits, including at or below the in-network level of cost-sharing, regardless of other coverage terms and conditions ([42 U.S.C §300gg-111\(a\)](#)).

This last requirement correspondingly requires health carriers to apply any cost-sharing towards an insured's or enrollee's deductible and out-of-pocket maximum, as if the service was in-network. These provisions also generally apply to services provided by air-ambulance ([42 U.S.C. §300gg-112](#)).

## ***Cost-Sharing***

Generally, the act requires insurers to calculate the patient's cost-sharing (i.e., coinsurance, copay, or deductible) as if the emergency service was provided in-network. For example, if a patient's in-network cost-sharing for the service is a \$15 copay, he or she will have the same \$15 copay for applicable out-of-network emergency services. Because the act bans balance billing, this cost-sharing amount is the total the patient is required to pay, regardless of the service's cost.

In practice, some individual cost-sharing is not a flat fee (like a copay) but is instead based on a service's cost (e.g., a coinsurance or deductible amount). For these circumstances, and for provider reimbursements described below, the act sets a service's cost based on the insurer's median in-network rate, as adjusted for inflation, determined by the Secretary of Health and Human Services (HHS) ([42 U.S.C §300gg-111\(a\)\(3\)\(E\)](#)). For example, if a patient's in-network cost-sharing is 20%, the patient will owe 20% of the median in-network cost for emergency surprise bills, up to the in-network out-of-pocket maximum and deductible.

If a state has already established a service's cost through either an all-payer model or a "specified state law" (see below), this established cost is considered the cost under the No Surprises Act. As a result, the cost would not be determined by the median in-network provision described above ([42 U.S.C § 300gg-111\(a\)\(3\)\(H\)](#)).

## ***Provider Reimbursement***

Within 30 days of receiving an out-of-network emergency bill, a health insurer or plan administrator must make an initial payment to the provider or facility or dispute the charge, after which either party may open negotiations. The payment must be the difference between the "out-of-network rate" and the patient cost-sharing described above.

Under the act, the "out-of-network rate" is the service's cost, as determined by an all-payer rate agreement or a specified state law. For states without such rates, it is the amount:

1. the parties agree to, including through open negotiations; or
2. determined through an arbitration process established under the act (i.e., the independent dispute resolution (IDR) process) ([42 U.S.C §300gg-111\(a\)\(3\)\(K\)](#) and [300gg-111\(c\)](#)).

## ***Specified State Law***

Connecticut has enacted its own surprise billing law that CMS considers a “specified state law” for purposes of the No Surprises Act. This law specifically prohibits health carriers from (1) requiring pre-authorization for emergency services and (2) charging a coinsurance, copayment, deductible, or other out-of-pocket expense that is greater than the in-network rate for an emergency service rendered by an out-of-network provider. The law also specifies the total amount payable for such services by requiring carriers to reimburse the out-of-network provider the greater of the (1) in-network reimbursement rate, (2) “usual and customary rate” for the service, or (3) Medicare rate ([CGS § 38a-477aa\(b\)](#)).

According to the federal [interim rule](#), a “specified state law” is a law that “provides a method for determining the total amount payable.... to the extent the state law applies.” Such a law must also apply to the (1) insurer, plan, or coverage involved; (2) out-of-network provider or facility; and (3) specific item or services involved.

According to a recent guidance from CMS, Connecticut law meets these requirements to the extent it is applicable to the specific services and providers in question. However, due to ERISA, state insurance laws do not generally apply to self-insured benefit plans. As a result, it appears that the federal act (and not state law) would govern cost-sharing and provider reimbursement for self-insured plans, as well as any services covered by fully-insured plans that do not meet the criteria above (e.g., if state law does not apply because the provider or facility is located out-of-state or the services are not covered under state law).

## **Non-Emergency Surprise Bills**

The act similarly requires surprise bills for nonemergency services from an out-of-network provider working in an in-network facility to be covered:

1. without the need for prior authorization;
2. regardless of whether the provider is in- or out-of-network; and
3. at the in-network level of benefits, including at or below the in-network cost-sharing, regardless of other coverage terms and conditions ([42 U.S.C §300gg-111\(b\)](#)).

The same cost-sharing requirements and calculations described above for emergency services apply to nonemergency services.

## ***Notification and Opt-Out Exceptions***

Depending on the surprise billing situation, the financial protections applicable to the patient will depend on whether he or she received notice about the provider's network status and knowingly consented to the out-of-network services. For example, if a patient receives notice six days before a scheduled service that the provider or facility is out-of-network, the financial protections included in the No Surprises Act do not apply. If services are being performed by an out-of-network provider as part of an in-network, in-patient stay, the patient must both be notified and consent to treatment by the out-of-network provider. Otherwise, the patient is covered by the act's protections. A recent Congressional Research Service (CRS) report, [Surprise Billing in Private Health Insurance: Overview of Federal Consumer Protections and Payment for Out-of-Network Services](#), provides a more detailed analysis of how surprise billing notices interact with the act's financial protections (see page 13, Table 4).

## ***Provider Reimbursement***

Within 30 days of receiving an out-of-network emergency bill, a health insurer or plan administrator must make an initial payment to the provider or facility or dispute the charge, after which either party may open negotiations according to the IDR process. Any payment must be the difference between the out-of-network rate and the patient cost-sharing, as described above. For these non-emergency surprise bills, the "out-of-network" rate is calculated the same way as it is for emergency services.

## ***Specified State Law***

The state's surprise billing law limits what an insured pays for nonemergency services. Under the law, an insured that receives a surprise bill is only required to pay the coinsurance, copayment, deductible, or other out-of-pocket expense that would have applied had an in-network provider rendered the services. A "surprise bill" is defined as a bill for non-emergency health care services from an out-of-network:

1. clinical laboratory if the insured was referred by an in-network provider or
2. provider at an in-network facility during a service or procedure performed by an in-network provider or previously approved by the health carrier, where the insured did not knowingly elect to receive the services from the out-of-network provider ([CGS § 38a-477aa\(a\)\(6\)](#)).

The law also requires health carriers to reimburse the out-of-network provider or insured, as applicable, for the services at the in-network rate under the plan as payment in full, unless the carrier and provider agree otherwise ([CGS § 38a-477aa\(c\)](#)).

Because state law provides a payment amount for these specified services, it appears to constitute a “specified state law” under the criteria described in the interim rule (see above). However, because state law generally applies only to fully insured plans, the No Surprises Act’s cost-sharing and provider reimbursement methodology would apply to self-insured plans. These federal requirements would also apply to nonemergency services covered by fully insured plans that are not encompassed in the state’s surprise billing definitions described above.

For more information on Connecticut’s surprise billing law, see OLR Report [2020-R-0204](#).

## Federal Preemption

[CRS’s analysis](#) of the No Surprises Act includes a detailed discussion of the law’s preemptive scope (page 23). Specifically, CRS notes that many of the act’s payment provisions set the floor for surprise billing regulation, and that “existing state laws—to the extent they impose the same or *additional* standards, requirements, or prohibitions on fully insured plans and providers as the federal law—are generally preserved, *unless* the additional standards, requirements, or prohibitions ‘prevent[] the application’ of a federal provision” (page 24).

However, CRS also notes that some state laws, such as those related to patient notification and consent to receive out-of-network services, may be construed by the courts to prevent the application of the federal Act. For example, if a state law offers less protection to consumers by allowing for a shorter notification period than under the act, it is likely preempted. It is also possible that state laws offering more consumer protections are preempted, such as laws prohibiting billing for out-of-network services even with appropriate notification.

## Further Information

More information is available in the Congressional Research Service’s [Surprise Billing in Private Health Insurance: Overview of Federal Consumer Protections and Payment for Out-of-Network Services](#) report, this [National Law Review](#) article, and the Connecticut Insurance Department’s [Consumer Alert](#).

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